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INFORMATIONAL LETTER #2005-1

DATE: March 10, 2005

TO: ALL IDAHO SKILLED NURSING FACILITIES/NURSING FACILITIES (SNF/NF'S)

FROM: DEBBY RANSOM, R.N., R.H.I.T., Chief

Bureau of Facility Standards

SUBJECT: RESIDENT ABUSE REPORTING IN SNF/NF'S

State law and federal regulations require that SNF/NF's report certain events to the survey agency. This guidance includes new and different reporting direction for facilities. This replaces all previous direction and training from the Department. Regulatory references include §483.13(b) and (c), and IDAPA 16.03.02.100.12.c. and f. Failure to comply with these reporting requirements may result in serious citation(s) at one or more of these regulations.

Types of Abuse that must be Reported:

- Physical abuse. This is non-accidental contact with a resident including hitting, kicking, slapping, biting, pinching. Report all such occurrences even if no mark is left on the resident.
- Sexual abuse. This includes sexual harassment or sexual assault. This further includes sexual behavior between two individuals, at least one of whom cannot make informed consent. For example, sexual behavior between two residents with Alzheimer's dementia, who are not able to form a rational decision, would be an incident of sexual abuse, even though the residents may be calm and agreeable.

If any resident alleges he/she was raped, it must be treated as a serious allegation of sexual abuse regardless of the resident's cognitive status. The police should be notified and an exam should be performed by qualified emergency room staff.

- Verbal or mental abuse. Examples include humiliation, threats of physical abuse or deprivation, or use of derogatory names. Resident-to-resident verbal/mental abuse need only be reported if it results in psychological harm, severe distress, or if it is a pattern of behavior (occurs three times or more).
- Involuntary seclusion. This includes separating a resident from other residents through confinement in a room against the resident's wishes. The Guidance to Surveyors at F223 explains special times when involuntary seclusion may be used as a last resort to keep residents safe.

Incidents that must be Reported:

- Resident-to-resident abuse incidents.
- Staff-, family-, visitor-to-resident abuse incidents. For incidents where a licensed nurse was the perpetrator, also notify the Board of Nursing at 208 / 334-3110.
- Resident injuries of <u>unknown</u> origin. These are injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; <u>and</u>, the injury includes severe bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones. Minor bruising and/or skin tears on the extremities need not be reported.
- Misappropriation of resident property by staff or others. This is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.
- Mistreatment The negligent commission or omission of acts that result in harm.
- Neglect Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Specific Possible Neglect Situations that must be Reported:

• Staff mistakes that result in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Some examples of staff mistakes include failure to adhere to the care plan, failure to

notify the physician timely of a significant change, failure to implement nursing standards. (See **Staff management** below.)

- Accidents involving facility-sponsored transportation resulting in resident injury.
 Examples: falling from the facility's van lift, wheel chair belt coming loose during transport, accident with another vehicle, etc.
- Resident elopement of any duration. Elopement is defined as when a resident who is unable to make sound decisions (B4 = 1, 2, or 3) physically leaves the skilled facility without the facility's knowledge.

For all of the above incidents: All allegations must be immediately reported to the facility's Administrator and to the Department's hotline, 1-208-364-1899. 'Immediately' means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident. Fax the completed investigation to the survey agency within five (5) working days, 1-208-364-1888. All investigation reports must include the facility's conclusions and actions taken to prevent a repeat occurrence of abuse. It is no longer necessary to call and speak to a supervisor directly when reporting any of the above incidents. You are still welcome to call if you wish.

Idaho's Adult Protection law further requires that when the facility has reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult, the facility must report this to law enforcement within four (4) hours.

Idaho's Skilled Nursing Facilities/Nursing Facilities do not need to report incidents of resident abuse, neglect, or exploitation to Adult Protection. IDAPA 39-5303 directs SNF/NF's to report these incidents to the Department.

Other Situations that must be Reported:

- Accidental death of a resident from any cause. This includes accidents that result
 in injury for which the resident is hospitalized, and subsequently dies in the
 hospital.
- Any resident death, from any cause, that occurs while the resident is physically restrained.
- Any occurrence that causes any resident(s) to be evacuated from any portion of the licensed facility.
- Planned admission of a registered (from any state) sex offender.

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For these four situations, call a Long Term Care Supervisor immediately at 208 / 334-6626 to report directly. Fax the completed investigation to the survey agency within five (5) working days, 1-208-364-1888. All reports must include the facility's conclusions and actions taken to prevent a repeat occurrence. For admission of a registered sex offender, be prepared to provide a detailed plan showing how residents will be kept safe from potential abuse.

All investigations must be signed by the Administrator within five working days of the allegation/incident. This signature indicates the administrator has reviewed the investigation, approves it as complete, and has ensured that appropriate measures have been taken. If the Administrator is out of the facility, his/her designee may sign the investigations. When the Administrator is on duty, this responsibility cannot be delegated to other staff.

Staff Management:

- If the facility determines that a staff member abused a resident, F225 requires the facility to terminate the staff member.
- If a staff member makes an error that meets the definition of neglect (above), the incident must be reported to the survey agency. However, the regulations do not require the termination of the staff member unless the facility concludes the neglect was intentional (willful or deliberate). The Bureau will not open a CNA case on reported incidents of CNA neglect unless the facility's investigation provides evidence the neglect was intentional.

Investigation Guidance:

A thorough investigation is critical to developing effective prevention strategies. Each facility is required to have a policy/procedure related to incident investigation. Every incident is unique. Facility investigators must ask the probing question to get to the root cause. While no guidance can identify every aspect of a good investigation, some essential components of a thorough investigation include:

- Date and time of the incident.
- A clear and legible description of exactly what occurred.
- All pertinent staff (or other witnesses) must be interviewed and the results of the interview documented in some form. Whenever possible, have witnesses sign a written statement.

- If a staff person is accused of any of the above, that person must be interviewed regarding the allegations and that interview must be documented. The facility must attempt to get a signed, written statement from the accused. If the accused refuses to give a signed written statement, the facility must document that refusal along with the interview.
- Interview the resident(s) involved.
- All visible injuries must be **measured** and described in detail.
- In cases of injury of unknown source, all staff having possible contact with the resident over the 24 hours prior to injury discovery must be interviewed.
- In cases of unwitnessed incidents, the facility needs to determine when the resident was last observed by staff and what the resident was doing at that time.

The facility must determine whether specific care plan approaches intended to prevent incidents (such as alarms, call light within reach, observation at designated intervals), were being implemented as planned.

[original signed by Debby Ransom & on file at the Bureau of Facility Standards]

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Bureau of Facility Standards

DR/nah

c: Idaho Health Care Association